DELAWARE DEPARTMENT OF INSURANCE
DPO – HMO – HSC ANNUAL FEES ASSESSMENT FORM
FOR CALENDAR YEAR 2007, DUE MARCH 1, 2008
GENERAL INFORMATION AND FILING INSTRUCTIONS

The calendar year 2007 Annual Fees Assessment Form is specifically developed for Dental Plan Organizations (DPO), Health Maintenance Organizations (HMO), and Health Service Corporations (HSC). This form was introduced in 1999, and reflects that although these companies are exempt from paying premium taxes to the State of Delaware, the companies are subject certain annual fees as listed below.

The completed form and remittance must be received on or before March 1, 2008, at one of the Bank lockbox addresses listed on the Form. **Note: Delaware uses a received by date, not a postmark date.**

IMPORTANT: DO NOT SEND THE ANNUAL FEES ASSESSMENT FORM OR REMITTANCE WITH THE ANNUAL STATEMENT: Annual statements are received at a different section of the Insurance Department. If you send the form and check in the annual statement, the filing may not reach the tax collections department in a timely manner and the company will be assessed a $100.00 per business day administrative penalty for late filing. The date the form is received in the tax department will be used for the delivery date on which the penalty will be assessed.

INSTRUCTIONS

(References are to Title 18, Delaware Insurance Code)

COMPANY INFORMATION AND MAILING ADDRESS

Complete all Company Information. List the address and contact person to whom annual tax and/or fees information or questions should be directed.

PAYMENT INFORMATION

The State of Delaware Insurance Department accepts tax and/or fees payments electronically using an ACH CCD+ format. Although using electronic payment is optional, the State encourages all companies to participate. Any company wishing to participate must be authorized to do so before electronic funds transfers may begin. Please refer to the Electronic Funds Payment Guide for information.

If paying by check, make check payable to: **Delaware Insurance Department**
Attach check to Form as indicated. Mail to National City Bank lockbox address as listed

ANNUAL TAX AND/OR FEES

Line 1 -- CERTIFICATE OF AUTHORITY RENEWAL FEE

Dental Plan Organizations enter:	$100.00	(§701; §3804(c))
Health Maintenance Organizations enter:	$100.00	(§701; Regulation 58, §6)
Health Service Corporations enter:	exempt	(§6304)

Line 2 -- ANNUAL STATEMENT FILING FEE

All companies enter:	$100.00	(§701; §526)

Line 3 -- FRAUD PREVENTION BUREAU ANNUAL FEE

All companies enter:	$550.00	(§2415)

Line 4 – TOTAL AMOUNT DUE

Sum Lines 1 through 3. Remit this amount.

AFFIDAVIT

Complete all sections and obtain signatures as indicated.

QUESTIONS should be directed to: Ann Fletcher, Tax Coordinator via email at:
Ann.Fletcher@state.de.us

DO NOT RETURN THIS PAGE

STATE OF DELAWARE DEPARTMENT OF INSURANCE
2007 ANNUAL FEES ASSESSMENT FORM
FOR THE CALENDAR YEAR 2007, DUE MARCH 1, 2008

Original Report ☐
Amended Report ☐

DPO–HMO–HSC

MAILING INSTRUCTIONS

Attach Check Here

The Delaware Insurance Department has established a lockbox operation for the collection of taxes and fees. This completed 2007 Annual Fees Assessment Form and accompanying check must be received at one of the bank addresses listed below on or before March 1, 2008. Filings received after that date will be considered late and the company may be subject to an administrative penalty of $100.00 per business day until the filing is received. *Please note: The Delaware Insurance Department uses a "received by" date, not a postmark date.*

If using U.S. Postal Service (regular mail):	**If using Courier or Express Service (overnight delivery):**
Delaware Insurance Department c/o National City Bank 6705 Reliable Parkway Chicago, IL 60686 **NOTE**: this is a PO Box – no personnel are present to receive deliveries	Delaware Insurance Department c/o National City Bank Attention: Lockbox # 6705 5635 S. Archer Ave. Chicago, IL 60638-1656

COMPANY INFORMATION AND MAILING ADDRESS

If this address or any other Company information changed during the calendar year, Check this Box ➔ ☐

Company Name: _____ Federal E.I.N. #: _____

Contact Person: _____ N.A.I.C. #: _____

Contact E-mail: _____ N.A.I.C. Group #: _____

Contact Phone and Ext.: _____ Fax: _____ State of Domicile (abbr.): _____

Contact Address: _____

_____

City – State – Country – Zip + 4: _____

Questions should be directed to:
Mrs. Ann Fletcher
Premium Tax Coordinator
E-mail: Ann.Fletcher@state.de.us

PAYMENT INFORMATION (Select One)

NOTE: Authorization Agreement approval required for ACH Credit Option

☐ **ACH CREDIT** Enter Transmittal Date: _____

☐ **CHECK** Enter Check Number: _____

Make check payable to "Delaware Insurance Department"

ANNUAL TAX AND/OR FEES

1.	Certificate of Authority Renewal Fee:	$
2.	Annual Statement Filing Fee:	$ 100.00
3.	Fraud Prevention Bureau Annual Fee:	$ 550.00
4.	TOTAL AMOUNT DUE:	$

AFFIDAVIT

In accordance with 18 Del. C., §702 (a), the Premium Tax and Fees Report shall be verified by the oath or affirmation of the President and Secretary or other responsible officer of the insurer, duly administered by a person authorized to administer oaths.

STATE of _____, COUNTY of _____, on this _____ day of _____ 20_____, before me, the subscriber, personally appeared _____ (PRESIDENT), and _____ (SECRETARY) of the above named Insurer who being duly sworn (or affirmed) deposes and says that this report and all schedules are true, correct, and complete.

Company Officer Signature _____ ***Title*** _____

Company Officer Signature _____ ***Title*** _____ *(Company Seal)*

If signed by Company Officer other than President or Secretary, state reason: _____

SWORN TO (OR AFFIRMED) AND SUBSCRIBED BEFORE ME THE DAY AND YEAR AFORESAID.

Signature (Notary Public) _____ Date Commission Expires _____ *(Notary Seal)*